

## CONFERENCE ABSTRACT

### Familiar faces: sharing expertise to plan frequent users of emergency services

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**Background:** The Hammersmith & Fulham Integrated Care Programme is a core group of healthcare organisations in Hammersmith and Fulham working in partnership to develop a better way of providing care. Together, we will re-shape the health and care system in Hammersmith and Fulham to respond to a range of health challenges within the borough and the rest of the country. For example, providing care for people living with one or more long term condition and system issues, such as overly fragmented care.

**We are working to:** design a practical, 'accountable care' approach - collectively looking after the whole health needs of local people, from beginning to end of life, rather than providing less joined-up treatment when they are ill.

identify and implement immediate improvements to 'join-up' care, primarily through two pilot projects, one focusing on patients who are frequent users of A&E services and a second looking at ways of boosting child health.

build strong foundations for potentially forming or becoming part of a formal accountable care partnership with pooled resources and shared clinical and financial risk so that we can genuinely provide whatever care is best to meet individual needs.

The programme will seek to work in partnership with commissioners, patients and the public wherever possible and ensure they are informed of plans as they develop.

Report to Board on Progress in Familiar Faces Project

This project was aimed at analysing the attendance of H&F GP registered patients at Emergency departments operated by Imperial, Chelsea and Westminster and other acute providers from April 2015 to January 2016.

This analysis identified 71 patients from across 22 practices who attended A&E more than 10 times, of which 13 have attended more than 20 times and 1 attended over 100 times.

After extensive information governance consultation, patients were approached by their general practitioners to be consented for full information sharing between providers for data to analyse their patterns of healthcare and define any unmet needs, or improvements that could be made in service efficiency and patient outcome.

An experienced GP was involved in the consenting of these patients which resulted in 20 patient giving their explicit consent.

A multidisciplinary review of all consented case records took place including clinicians from all partners.

**Summary Findings:** The patients who were considered by in depth notes review, revealed that remarkable effort had been made both by staff in Emergency Departments but also in General Practice, in Outpatients and in Mental Health Care to meet the needs and co-ordinate the care of those individuals who frequently attended ED.

That significant examples of duplication of effort were discovered especially for outpatient referral and communications being disrupted because of the separation of information systems and clinical data barriers, which we believe result in significant inefficiency and duplication of cost in the system.

That, despite extensive searching for care plans, these did not appear to be visible in any of the systems and where attempts at this were found, duplication of care plans with no version control was highlighted as an issue.

In clinical terms there appear to be three main clusters of patients. One group of patients in which alcohol and mental illness compounded physical conditions particularly arteriopathy and cardio respiratory problems as well as pain syndromes. Secondly patients with indwelling catheters sometimes who also had recent treatment for malignancy and or neuropathy. Thirdly, patients who had drug and alcohol problems which acted as barriers to further referral into mental health in the community and which patient was able to refuse, after yet another ED attendance, any further assistance from their General practitioner when the call was made under the avoidance of admission protocol.

**Outcomes:** There was a major theme that the collaborative work being done in ED involving greater and more acute involvement of psychiatry from West London Mental Health Trust should be further developed across our accountable care partnership, building upon previous work undertaken by the Liaison Psychiatry Services.

There was also further discussion that the patient voice should be heard regarding how they would perceive their needs to be met and a subsequent qualitative piece of work undertaken to interview a subsample of patients.

Opportunities for collaborative care planning are being explored to reduce the use of unscheduled care by these patients and to improve identification of these high impact users of emergency services routinely in future.

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